Kentucky Department for Medicaid Services

Frequently Asked Questions

1. **Do I need to fill out survey if I did not receive DSH payments during the DSH year?**
   No, if you did not receive DSH payments during the DSH year being audited then the survey is not required.

2. **Which Medicare cost report do I use the as submitted or final?**
   Use the best information available. If audited Medicare cost reports are available, they should be used to complete the survey. If the final Medicare cost report is not available, the Medicare as filed cost report can be used.

3. **Should the information on the survey be reported in the state's DSH year or the provider's FYE (Cost Report period)?**
   The information reported on the survey should contain information based on the cost reporting periods that fall throughout the DSH year. **The entire cost report FYE should be reported.** Providers should check their cost reporting period for accuracy.

4. **Do I report all or sample FFS and managed care payments?**
   All payments related to the cost reporting periods should be reported.

5. **Should I include all cost to charge and fixed fee charges and payments from the Medicaid FFS PCLs?**
   Yes

6. **Should KHCP days be included on the DSH survey?**
   Yes, these are your DSH indigent care days. However, make sure all uninsured patient days reported satisfy the CMS definition of uninsured.

7. **Do I need data from my PCLs?**
   Yes, we encourage you to utilize the Medicaid paid claims listings, FFS Crossover, and MCO data provided. Please review all paid claims listings for accuracy. If submitting internally-generated patient detail, please provide a detailed reconciliation upon submission.

8. **Which Medicaid PCL do I use – should I use the PCL that was filed with my cost report?**
   No, DMS will send you an updated Kentucky Medicaid FFS PCL.

9. **Where do I get the remaining data? (i.e., the out-of-state and uninsured data)?**
   A provider can utilize hospital records; however, an out-of-state paid claims or remittance advice documentation must be submitted for support.

   The uninsured data has to come from the provider's internal patient accounting system. This typically involves getting their IT department involved to pull data in order to complete Exhibit A, B, and/or C.

10. **If I can't obtain my out-of-state PCL records, can I use my remittance advices as source documentation for Section I of the survey?**
    Yes, but we would need a summary worksheet or summary log submitted with the survey. Please keep available all the source documentation used to create the summary in the event it is requested during audit.

11. **Should non-covered charges from the PCL be included in the survey?**
    No.

12. **Which revenue code crosswalk should be used to report the data in the appropriate cost center: a.) the current crosswalk, or b.) the crosswalk used to originally complete the relevant cost report periods (i.e., crosswalk in place during the 2012 period)?**
    Providers should utilize the crosswalk in place at the time of completion of the cost reports, if available. Only if the 2012 crosswalk cannot be located should a provider use the current crosswalk to group data to the cost centers on the survey. If the current crosswalk is used, a note in the survey submission should be provided that describes why the original crosswalk was not utilized.

13. **Should discounts be netted from gross charges?**
    All gross charges should be reported in the survey.

14. **On Section F of the survey, if I use my Medicare G-3 to complete the section F – the G-3 Medicare schedule has contractuals with bad debt included; can I back out the bad debt and provide supporting documentation?**
    We have updated the surveys to include a reconciliation of the contractual adjustments included on G-3. Please provide additional documentation to support the reconciling items listed in this section.

15. **Can I submit consolidated Financial Statements – if the notes detail the charity amount for the hospital?**
    Yes, as long as we can identify the charity amount related to the hospital on the survey.

16. **Are home health and ambulance on Schedule F as non-hospital?**
    Yes, report these in the non-hospital column.

17. Can I add additional ancillary cost centers on Schedule G?
Yes, all data should reconcile, additional lines are provided to ensure your data can be fully reported. These cost centers are consistent with your Cost Report Worksheet C – Part I; however, only allowable cost centers should be input.

18. Do I include the zero paid nursery days from the PCL on Schedule H?
Yes, zero paid nursery days are included, along with the nursery per diem cost on Schedule H. These are Medicaid eligible patients that are receiving an approved State Plan service, so their cost is part of the hospital-specific DSH limit.

Note – just to clarify, this is different than the non-covered charges on the PCL. Those are NOT included on Schedule H – because they are not an approved state plan service and should not be included in the DSH limit.

19. Will my Schedule H uninsured column agree in total to the Exhibit A?
No, only report the **hospital non-professional charges** on Sch. H. All will be listed on the Exhibit A but they will be sub-totaled and only the hospital non-professional piece will be brought to Sch. H. For instance, the provider should not carry over the RHC line items (and any additional non-allowables) reported on Exhibit A, to the Schedule H.

20. How should additional cost centers on the PCL be treated if they didn't have their own cost to charge ratio on Sch. C?
Those should be treated consistent to how they were treated on their Medicare cost report then provide support for where those charges are reported.

21. How should professional fees be handled?
For Schedule H and I – professional fees should <u>not</u> be included in the charges for hospital inpatient or outpatient services.

Note: Professional fees are not included in the hospital-specific DSH limit therefore not reported throughout the survey in data used to arrive at the DSH limit.

However, for Exhibit B – professional charges for I/P and O/P should be reported in the separate column in order to accurately calculate the collections attributed to the hospital's uninsured. Reporting professional charges on Exhibit B will apportion the cash collections between the services.

22. How should crossover bad debt payments be reported? Can the cost report W/S E, Part I, be used?
Yes, if you have a break-out of your cross-over bad debts on your cost report including any rehab or psychiatric units. If you can't get it from the cost report you can use your own records and supply documentation to support it.

Please note: This amount will be compared to a calculated estimate based on the cross-over claims data and may be adjusted.

23. How should outpatient settlement payments be handled? Reported for the cost report year, or reported in the year received / paid? Should you include the payment made when filing the cost report?

When an outpatient settlement is completed and a payment is either received or paid, those payments should be reported in the year that the payment relates to (i.e., accrual basis, not cash basis). Yes, those interim payments made when filing the cost report should be reported since the payment is not reflected in the PCL.

24. Please provide an example of a subsidy.

Anything received to subsidize uninsured patient care. These vary from state to state and are rare – would come from state or county, typically.

25. What is the definition of uninsured for Medicaid DSH purposes?

Uninsured patients are individuals with no source of third party health care coverage (insurance) or third party liability for the specific service provided. Prisoners must be excluded.

- CMS released a **final** rule in the December 3, 2014 Federal Register to clarify the definition of uninsured and prisoners.
- Under this final rule, the DSH examination will now look at whether a patient is uninsured using a "service-specific" approach as opposed to the creditable coverage approach previously employed.
- The survey does allow for hospitals to report "exhausted" and "insurance non-covered" services as uninsured.

Excluded prisoners were defined in the proposed rule as:

- Individuals who are inmates in a public institution or are otherwise involuntarily held in secure custody as a result of criminal charges. These individuals are considered to have a source of third party coverage.
- Prisoner Exception
    - If a person has been released from secure custody and is referred to the hospital by law enforcement or correction authorities, they can be included.
    - The individual must be admitted as a patient rather than an inmate to the hospital.
    - The individual cannot be in restraints or seclusion.

26. What is meant by "Exhausted" and "Non-Covered" in the uninsured Exhibits A and B?

Under the December 3, 2014 final rule, hospitals can report services if insurance is "exhausted" or if the service provided was "not covered" by insurance. The service must still be a hospital service that would normally be covered by Medicaid.

27. What categories of services can be included in uninsured on the DSH survey?

Services that are defined under the Medicaid state plan as a Medicaid inpatient or outpatient hospital service may be included in uninsured *(Auditing & Reporting pg. 77907 & Reporting pg. 77913)*

- There has been some confusion with this issue. CMS attempts to clarify this in #24 of their FAQ titled "*Additional Information on the DSH Reporting and Audit Requirements*". It basically says if a service is a hospital service it can be included even if Medicaid only covered a specific group of individuals for that service.
    - EXAMPLE: A state Medicaid program covers speech therapy for beneficiaries under 18 at a hospital. However, a hospital provides speech therapy to an uninsured individual over the age of 18. Can they include it in uninsured? The answer is "Yes" since speech therapy is a Medicaid hospital service even though they wouldn't cover beneficiaries over 18.

28. Can a service be included as uninsured, if insurance didn't pay due to improper billing, late billing, or lack of medical necessity?

No. Improper billing by a provider does not change the status of the individual as insured or otherwise covered. In no instance should costs associated with claims denied by a health insurance carrier for such a reason be included in the calculation of hospital-specific uncompensated care (would include denials due to medical necessity). *(Reporting pages 77911 & 77913)*

29. Can unpaid co-pays or deductibles be considered uninsured?

No. The presence of a co-pay or deductible indicates the patient has insurance and none of the co-pay or deductible is allowable even under the proposed rule. *(Reporting pg. 77911)*

30. Can a hospital report their charity charges as uninsured?

Typically a hospital's charity care will meet the definition of uninsured but since charity care policies vary there may be exceptions. If charity includes unpaid co-pays or deductibles, those cannot be included. Each hospital will have to review their charity care policy and compare it to the DSH rules for uninsured.

31. Can bad debts be considered uninsured?

Bad debts cannot be considered uninsured if the patient has third party coverage. The exception would be if they qualify as uninsured under the final rule as an exhausted or insurance non-covered service.

32. Can a hospital report services covered under automobile polices as uninsured?

Not if the automobile policy pays for the service. We interpret the phrase ''who have health insurance (or other third party coverage)'' to broadly refer to individuals who have creditable coverage consistent with the definitions under 45

CFR Parts 144 and 146, as well as individuals who have coverage based upon a legally liable third party payer. The phrase would not include individuals who have insurance that provides only excepted benefits, such as those described in 42 CFR 146.145, unless that insurance actually provides coverage for the hospital services at issue (such as when an automobile liability insurance policy pays for a hospital stay). *(Reporting pages 77911 & 77916)*

33. On Exhibit A, what do patient identifier and routine days of care mean?

Patient identifier is the internal patient account number and routine days of care are the patient length of stay.

34. How should I sort my data on Exhibit A?

Exhibit A should be sorted by service indicator and then by revenue code this will enable you to group your charges on Section H of the survey.

Service indicator should separate the data between inpatient and outpatient. Once the data is separated in that fashion, the inpatient days and charges should transfer to the Schedule H for uninsured. Once separated by revenue code – all the same revenue codes can be summed up and transferred through the provider's crosswalk into the appropriate cost center on the survey. This process is identical to your Medicare cost reporting principles.

FYI- This process can also be followed to obtain your out-of-state data for out-of-state Medicaid, out-of-state MCOs, and out-of-state Crossovers. Once your IT department pulls all out-of-state patients, you should be able to sort and categorize patients into the various payers needed (out-of-state Medicaid, out-of-state MCO, and out-of-state crossovers). Once you've separated by payer, then following the same routine by sorting by service indicator, then by revenue code, summing by revenue code, then using the crosswalk to ultimately report data in appropriate cost centers on Schedule I of the survey.

35. If I don't have detailed information, can I spread my charges or estimate?

Spreading is acceptable as long as you have patient level detail for the charges.

36. How are patient payments to be reported on Exhibit B?
Cash-basis! Exhibit B should include patient payments collected during the cost report period (cash-basis). Under the DSH rules, uninsured cost must be offset by uninsured cash-basis payments.

37. How do I handle cash collections through an external collection agent?
The actual cash remitted back to the provider via the third party collector is the amount to be reported on Exhibit B uninsured.

38. What is considered a self pay cash collection for Exhibit B?
All payments received from patients. For insured patients these would include payments such as deductible, copay, and coinsurance.
Note: An indicator must be provided on Exhibit B to show if the patient is insured or uninsured.

39. Should we include state and local government payments for indigent in uninsured on Exhibit B?
Uninsured payments do not include payments made by State-only or local only government programs for services provided to indigent patients (no Federal share or match). *(Reporting pg. 77914)*

40. In the "insured" column on Exhibit B – should we include co-pay and deductibles?
Yes, it would include any payment from the patient.

41. Should Exhibit B be including all self-payments?
Exhibit B should include all insured and uninsured self-payments.

42. Is it necessary to split out I/P and O/P on self pay – the cost to charge ratios are the same for ancillary services for both I/P and O/P?
Yes – These should be reported separately.

43. For self pay, can we include charges and related expenses for Ambulance and DME service lines?
According to CMS, Ambulance and DME are not considered hospital services – therefore should not be included in the survey to determine the hospital-specific DSH limit.

44. What is required on Exhibit B-1?
Exhibit B-1 is not required and is only used if a provider doesn't have insurance status on old records.

45. Are Exhibit A, B, and B-1 supposed to allow data entry – are these a template or merely an example data layout?

These exhibits were not designed for data entry. These are for illustrative purposes of how a provider may pull data from their system. This detailed information must be submitted along with the survey. Each provider may report this differently, although these basic data elements as illustrated in the exhibits are required. Please note – providers should follow the formula methodology outlined in the exhibit for calculating the hospital uninsured collections. By pulling up the electronic file, a provider can see the formula in the last column and mirror that methodology using their created exhibit and relevant columns.

46. If a patient is totally self-insured, do they appear on Exhibit A and Exhibit B for the survey?

Yes, a patient that is self-insured with no health insurance or other third party coverage receiving services defined as inpatient or outpatient hospital services consistent with services under the Medicaid state plan would be considered as uninsured.

The patients should be included on Exhibit A and Exhibit B (self-insured charges and relevant data is reported on Exhibit A, and all payments received related to the self-insured patient's service is reported on Exhibit B).

Note: Exhibit B may also include other payments received during the cost report period that relate to patients from a prior period that are not reported on Exhibit A.

47. Is my cost report being audited?

No

48. How should I get started on my survey?

See a copy of DSH Tips located at http://chfs.ky.gov/dms/dsh.htm or please contact Myers and Stauffer and we will email you a copy.